Advancing Health Equity and the Cost of Inaction

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Humana

Disclosures

Humana.

Our Current Healthcare Landscape

Evolving consumer population

By 2050, racial and ethnic minorities will comprise almost half of the population; 20% will be elderly and 35% of this elderly population will be racial and ethnic minorities

Incongruent workforce for membership

In 2018, about 13% of the U.S. population was Black, but only 5.4% of physicians were Black

Persistent health disparities

A higher proportion of elderly Blacks and Latinos, compared to Whites, state that they have at least one of seven chronic illnesses

Perceived healthcare inequities

In the U.S., one in four Black and Latinx/Hispanic adults age 60 and older reported that they have been treated unfairly or have felt that their health concerns were not taken seriously by health professionals because of their racial or ethnic background.

Physician-patient concordance impacts health outcomes

Shared racial identity between a physician and an infant is associated with significant improvements in mortality

Sources: https://www.census.gov/prod/1/pop/p25-1130.pdf, https://www.commonwealthfund.org/, https://www.commonwealthfund.org/publications/issue-briefs/2022/apr/how-discrimination-in-health-care-affects-older-americans, https://link.springer.com/article/10.1007/s11606-021-06745-1 , https://www.pnas.org/content/117/35/21194?_ga=2.112472580.1279199570.1599254213-1560094452.1599254213

Health Disparities in Ohio

Ohio ranks 44th among states for overall well-being. This can partially be attributed to inequities as Ohio ranks 47th in the country for how poorly the health of lower income residents compared to higher income Ohioans[1].

Black Ohioans have lower life expectancies, higher rates of obesity and diabetes, and higher levels of infant mortality and low birth weights*. Given the connection between poverty and health, the poverty rate for Black Ohioans is 2.6x higher than White Ohioans[1].

Ohio ranks 8th worst in the nation for black-white housing segregation. Racially-segregated areas often experience generational poverty, lack of resources, increased rates of violence, and riskier behaviors– all of which contribute to poor health[1].

*As compared to White Ohioans

Sources: [1]Policy Matters Ohio (https://www.policymattersohio.org/research-policy/sustainable-communities/health-health-equity/building-a-healthy-ohio)

Key Drivers of Health Disparities

Low Health Literacy

Nearly **9 of 10 adults** struggle to understand health information, which can include prescription instructions, doctor orders, and insurance benefits.[1]

Low health literacy disproportionately affects **lower socioeconomic groups, minority groups, older adults, and people with disabilities.**[2]

Mistrust

In a study, only **64%** of the public agreed that U.S. healthcare system could be trusted.[3]

Black and Hispanic patients report lower trust in their primary physician than White patients.[3]

Bias and Discrimination

1 in 4 older adults of color reported they were treated unfairly or ignored by healthcare professionals due to race/ethnicity.[4]

Older U.S. adults are **more likely** to report racial and ethnic discrimination in the health system compared with their peers in 10 other high-income countries.[4]

Social Health Needs

50 percent of a person's health is determined by social and environmental factors like food, housing, transportation, social support, and financial security.[5]

In a year, **68 percent of U.S. adults experience at least one unmet social need**. Those with an unmet need were **twice as likely to rate their health as fair or poor** compared to those who did not.[6]

Sources: [1] National Library of Medicine (https://www.nnlm.gov/guides/intro-health-literacy) [2]American Journal of Preventive Medicine vol. 36,5 (DOI: 10.1016/j.amepre.2009.02.001) [3]NORC at the University of Chicago (https://www.norc.org/PDFs/ABIM%20Foundation/20210520_NORC_ABIM_Foundation_Trust%20in%20Healthcare_Part%201.pdf) [4]AARP (https://www.aarp.org/health/conditions-treatments/info-2022/health-provider-discrimination.html [5]County Health Rankings (https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model) [6]RISE Health (https://www.risehealth.org/insights-articles/social-determinants-of-health)

“The underlying problem of health care spending is health inequity.”

Pierre Theodore, MD
Vice President, Health Disparities
Johnson & Johnson Global Public Health

Compared to peer nations, the US ranks near the bottom in health outcomes, while **continuing to exceed other countries in health spending**

Highest per capita spending on healthcare[1]

$320 Billion
Cost of healthcare inequities today[2]

Expected changes in population, cost of care, and per capita spending

$1 Trillion
Cost of healthcare inequities by 2040[2]

All other countries with health expenditures more than 10% of GDP have a lower infant mortality rate and higher life expectancy than the United States[1]

26th
out of 35 in life expectancy[1]

29th
out of 35 in infant mortality[1]

Last/near last on access, administrative efficiency, equity, and health outcomes domains[1]

Sources: [1] America's Health Rankings (https://www.americashealthrankings.org/learn/reports/2016-annual-report/comparison-with-other-nations) [2] Deloitte (https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html)

How Health Disparities Contribute to Excess Healthcare Spending

- Healthcare spending is often higher among certain populations due to delayed care, access barriers, late and missed diagnoses[1].
- The approach below was used by Deloitte to model the impact of excess spending among affected populations:

Disease Area	Health Disparity	Annual Cost of Disease	% of spending associated with the disparity	Unnecessary Spending associated with the disparity
Diabetes	Black adults are 60% more likely than white adults to be diagnosed with diabetes and are two to three times more likely to have complications	$327 billion	4.8%	$15.6 billion
Asthma	The asthma rate for those living under the Federal Poverty Line (FPL) is 11% compared to -7% for those that are >2x over the FPL	$56 billion	4.3%	$2.4 billion

Sources: [1]Deloitte (https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html)

Long Term Impacts of Health Disparity

If unaddressed, health inequities and the additional $1 trillion in spending will raise healthcare costs to an unsustainable level[1]. If disparities are eliminated, $93 billion in excess medical costs and $42 billion in lost productivity could be saved (with today's numbers) giving the U.S a potential financial gain of $135 billion per year[2].

Excess healthcare costs will fall on individuals, resulting in lower rates of healthcare coverage and unaffordable medical bills. This will decrease access while increasing disease prevalence and morbidities. By making health equitable, quality of life and life expectancy could both improve[1].

There were almost 75,000 excess deaths among Black people compared with White people each year between 2016 and 2018, according to an analysis of all-cause mortality rates in the 30 largest U.S. cities[3]. It is estimated that there are 3.5 million lost life years associated with these premature deaths[4].

Sources: [1]Deloitte (https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html) [2] Kaiser Family Foundation (https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/) [3] JAMA Network (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775299) [4] WK Kellogg Foundation | Altarum (WKKellogg_Business-Case-Racial-Equity_National-Report_2018.pdf (altarum.org)

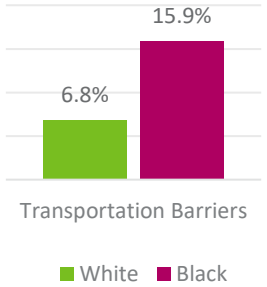
Health Inequities Among Humana Membership

Health Disparities between certain groups…

Access to Care

Black members have ***491 less*** specialty visits /1000 members[2]*

Black members have ***111 more*** Emergency Department visits /1000 members[2]*



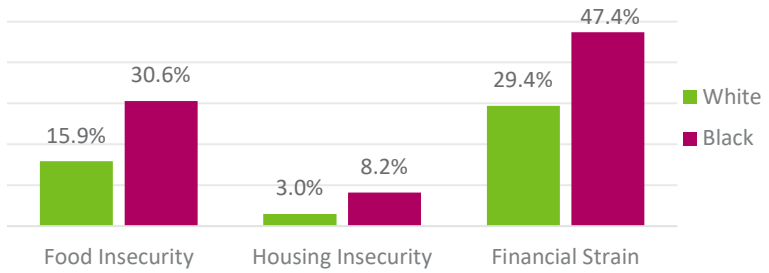
Quality of Care

15% Black MA members are 15% more likely to have a 30-day readmission[1]*

29% Black MA members are 29% more likely to have an Avoidable Hospitalization[1]*

Barriers to Healthy Living

Prevalence of health-related social needs[2]



…can lead to adverse outcomes

43% Higher rate of Diabetes for Black MA members[2]*

14% Higher rate of Hypertension for Black MA members[2]*

12% Higher rate of Cancer for Black MA members[2]*

1.3x Black MA members are 1.3x more likely to have a stroke[1]*

*As compared to White MA members

Sources: [1]AHEDD (Agile Health Equity Data Disaggregation), [2]Humana Population Health Analytics Suite, Data Updated through November 2022

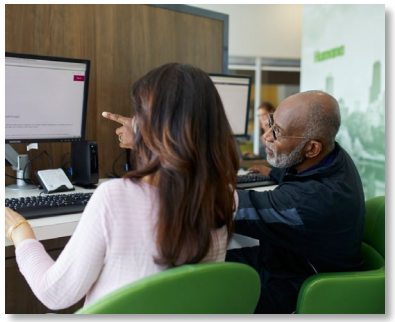
Our Health Equity and Social Impact team influences and enables health equity through three strategic priorities:

Improve access to care

Improve quality of care

Address barriers to healthy living

What Humana is Doing to Reduce Health Disparities



Health Literacy

- Develop health literacy focused programs and partnerships to empower members and patients in navigating their health and healthcare needs
- Create training and literature for Humana associates and sales agents on Health Literacy

Mistrust

- Partner, provide insights, and provide support to clinical quality and provider-facing teams to identify opportunities to close gaps in care and improve clinical outcomes
- Collaborate with Community Health Workers to increase PCP utilization

Bias and Discrimination

- Equip clinicians with tools to provide culturally humble and bias free care
- Create and facilitate programs and trainings to increase understanding of cultural differences and mitigation of cultural biases that impact engagement and clinical outcomes
- Collaborate with community and national partners to address longstanding disparities

Social Health Needs

- Connect members to over 500,000 community resources through Humana Community Navigator, an online tool used to identify resources that address social needs
- Leverage expertise in pilot testing, analyses, and research to influence product and plan design
- Influence EHR vendors to structure social needs data and offer more data interoperability with provider

Workforce: Humana is a growing employer in the state

164 | Humana associates dedicated to Ohio Medicaid; 62% are new associates within the past year

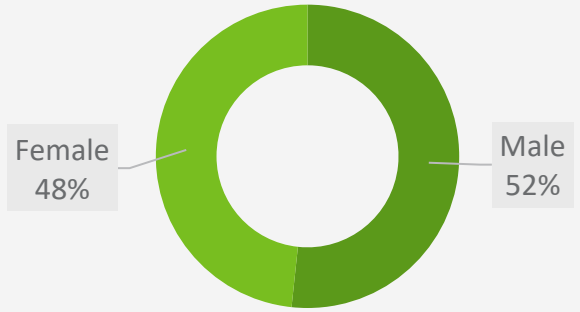
87% | Female associates; 32% are POC

Humana headcount report as of 4/6/23

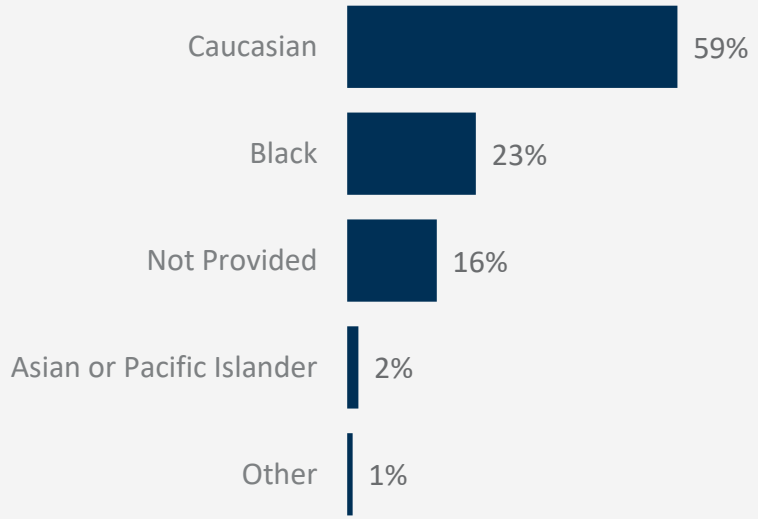
Ohio Medicaid: Humana Member Demographics

Approx. 75,000 Members

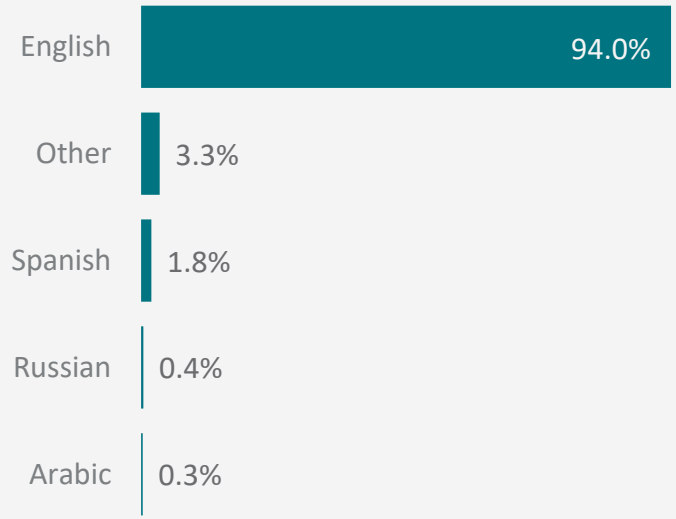
Gender



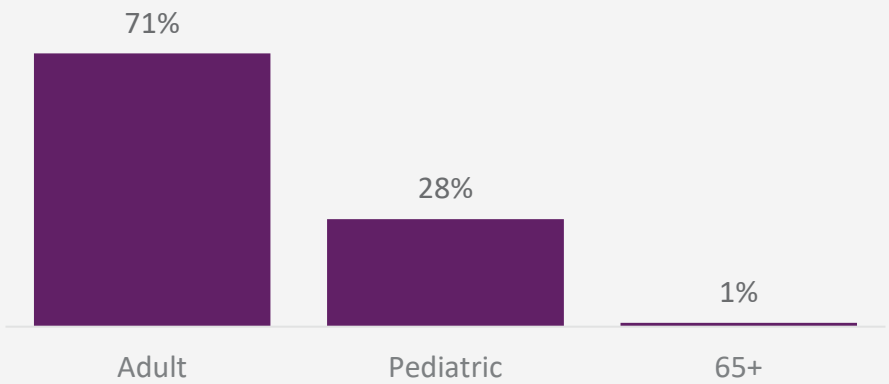
Race



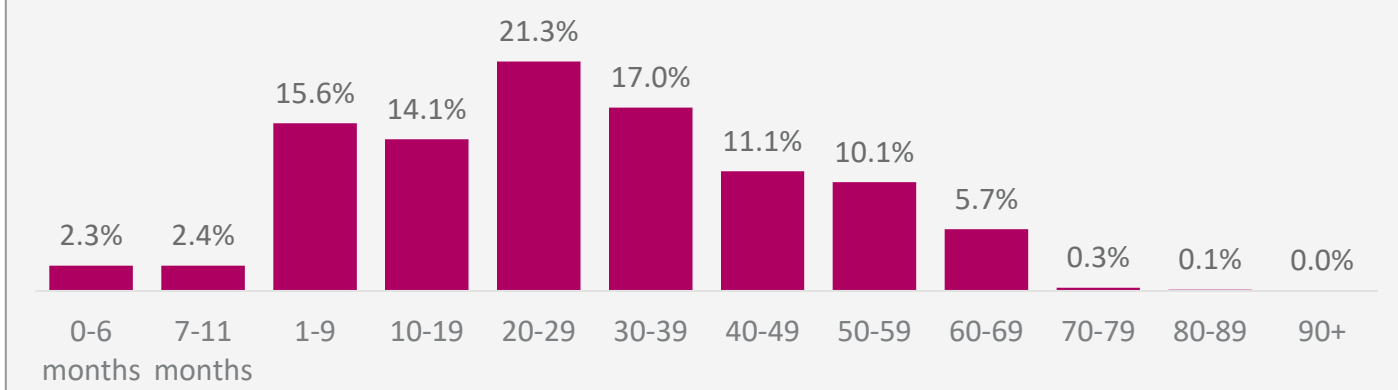
Language Spoken



Age Groups



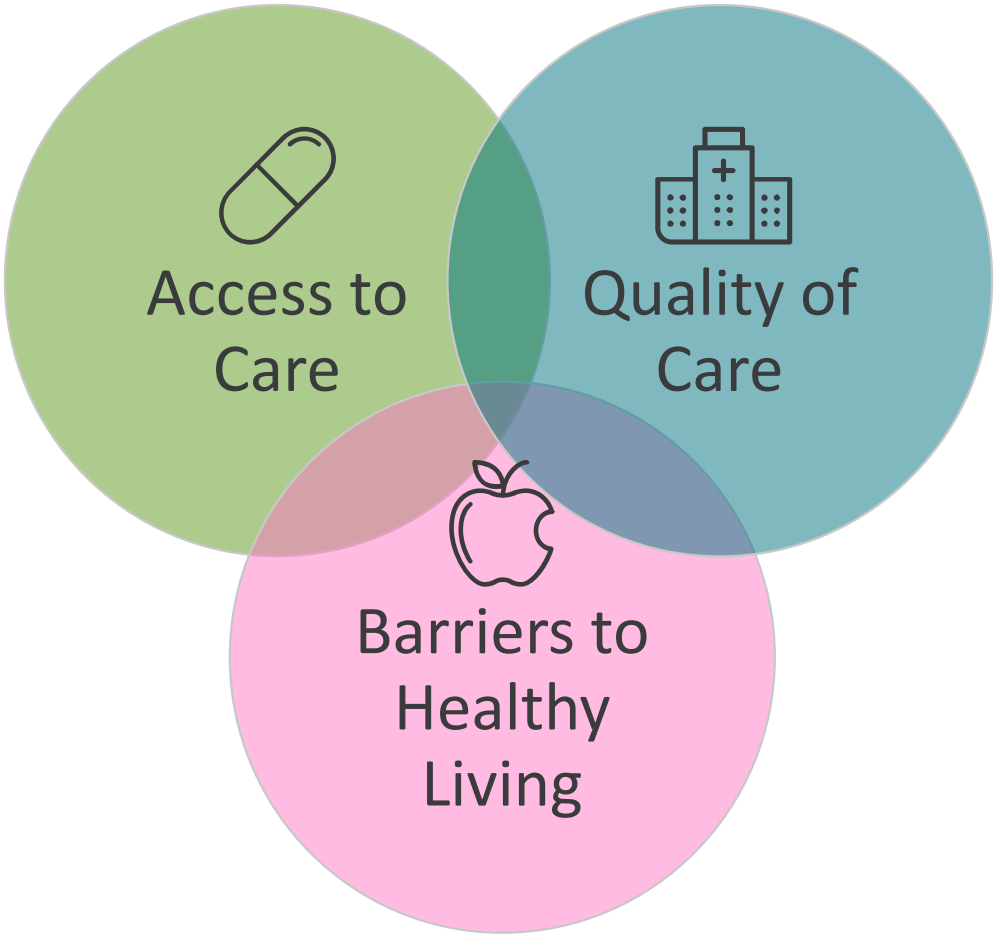
Age Bands



Active member data as of 3/31/2023

Population Health Analytics Suite

A Unified Platform for Utilization, Clinical, Social Needs & Community Data



- Open access to all associates
- Maps and harmonizes 90+ internal and external Data Governance Office certified data sources
- Includes 150+ key performance indicators
- Utilized by 220 different department cost centers in 2022

7 available report views provide the following capabilities:

Executive Summary

A high-level, comprehensive overview of clinical, business (cost and utilization), demographic, and social needs measures by line of business

SDOH Pulse

An aggregated view of all social health need assessments at an organization level

Highlights impact of social needs on cost, utilization, and clinical metrics

Population Health One

Allows for exploration of business, clinical, social needs, and community measures at varying geographic levels (Division/ Region/Market) for hotspot identification

3rd Party Data: 70+ *Robert Wood Johnson Foundation County Health Rankings measures*

Health Equity

Stratifies business, clinical, and social needs measures by Race, Language, Sex, Disability, Low Income, Rural-Urban, and Veteran Status

Maternity and Birth Outcomes

Trends of 15 delivery and 27 birth performance indicators by maternal race, age, condition, and geography

Allows side by side comparison to 3rd party community measures to better understand the relationship to delivery and birth outcomes

HEDIS/Quality for Medicare

Reports eligibility and compliance for 14 priority HEDIS (Healthcare Effectiveness Data and Information Set)/quality measures

Includes YOY Trends, differences in compliance by race, and compliance relationship to social needs and third-party measures

Self-Serve

Enables export of clinical, business, demographic, and social needs measures at a member-level for targeted interventions and ad-hoc analyses

Recent Use Cases

Retail – Market and Stars

- Understand the relationship between social needs and the compliance of HEDIS and quality measures so that targeted interventions can be developed to close gaps
- Highlight SDOH needs and opportunities that allow for informed conversations with provider groups about addressing gaps in their members

Health Equity

- Enable Health Equity strategy formation, in concert with health disparities data disaggregation work
- Identify SDOH, health conditions and other disparities to determine focus for pilot and benefit development

Data Analysts and Scientists

- Conduct ad-hoc analyses to identify health inequities and disparities in Humana's membership for targeted intervention development
- Create descriptive statistics to analyze utilization, social needs and engagement between population segments

Mental Health Focus

The Humana Foundation examples

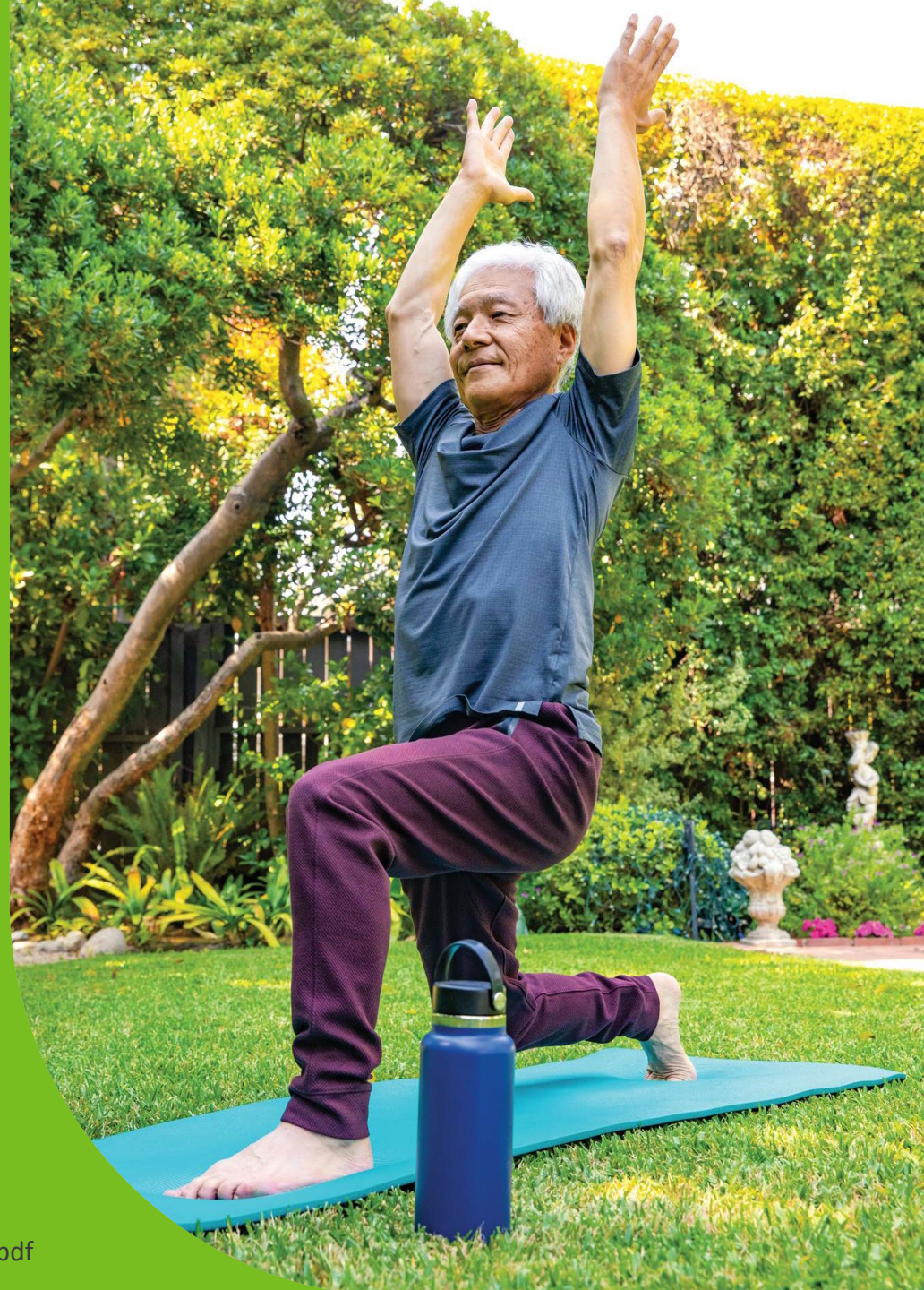
The Foundation has a **mental health** grantmaking/partnership strategy with emphasis on:

- **Senior companionship** (feeling of belonging and/or sense of community) (e.g., foster grandparent programs)
- Combatting **loneliness** (distressed feeling of being alone or separated) in diverse underserved populations of seniors, veterans and children (e.g., suicide prevention)
- Promoting **equity in mental health services**, with a specific focus on prevention (e.g., substance abuse prevention services)

Medicaid effort examples

Family Focused Recovery (FFR) + Volunteers of America (VOA):

- FFR is a holistic model where parent and child receive residential treatment together, thereby breaking the cycle of addiction, reducing health effects and costs and preserving the family unit.
- The VOA Family Focused Recovery Model (FFR) consists of three phases: intensive residential treatment, intensive outpatient while boarding and independent transitional living



https://populationhealth.humana.com/wp-content/uploads/2021/08/ChildrensIssuesBrief_EXTERNAL_Aug-2021.pdf

Health care effectiveness: our commitment to testing what works

Testing personalized, local models to improve access to care, measured through improvement in gap in care (GIC) closure

Ruby, age 75

- Has diabetes, hypertension
- Experiences financial strain, limited access to transportation, low health literacy
- Does not have a Primary Care Physician

VOLUNTEERS OF AMERICA

- West Louisville
- Chronic conditions, open GIC, low-income zip codes
- Delivered by a community health worker **(CHW)**

PAPA

- Rural Mississippi
- Chronic conditions, open GIC, social risk
- Delivered by a “youthful adult” **(Pal)** + virtual care navigation

DUOS

- Michigan
- Chronic conditions, open GIC, social risk
- Delivered by a virtual personal assistant **(Duo)**

Reminder: The cost of inaction

Highest per capita spending on healthcare[1]

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Cost of healthcare inequities today[2]

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“

I firmly believe none of us in this world has made it until the least among us has made it.

”

OPRAH WINFREY

Humana.